

# The emergence of cultural safety within kidney care for Indigenous Peoples in Australia

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## Abstract

Cultural safety is increasingly recognised as imperative to delivering accessible and acceptable healthcare for First Nations Peoples within Australia and in similar colonised countries. A literature review undertaken to inform the inaugural Caring for Australians with Renal Insufficiency (CARI) guidelines for clinically and culturally safe kidney care for Aboriginal and Torres Strait Islander peoples revealed a timeline of the emergence of culturally safe kidney care in Australia. Thirty years ago, kidney care literature was purely biomedically focused, with culture, family and community viewed as potential barriers to patient 'compliance' with treatment. The importance of culturally informed care was increasingly recognised in the mid-1990s, with cultural safety within kidney care specifically cited from 2014 onwards. The emergence timeline is discussed in this paper in relation to the five principles of cultural safety developed by Māori nurse Irihapeti Ramsden in Aotearoa/New Zealand. These principles are critical reflection, communication, minimising power differences, decolonisation and ensuring one does not demean or disempower. For the kidney care workforce, culturally safe care requires ongoing critical reflection, deep active listening skills, decolonising approaches and the eradication of institutional racism. Cultural safety is the key to truly working in partnership, increasing Indigenous Governance, respectful collaboration and redesigning kidney care.

## KEYWORDS

cultural safety, decolonising, Indigenous health, kidney care, nephrology

## 1 | INTRODUCTION/BACKGROUND

**Statement:** We recognise that Aboriginal and/or Torres Strait Islander peoples, Indigenous and First Nations peoples are terms used in Australia. However, First Nations and Indigenous are also utilised throughout this paper when reflecting an international context. We use the term Indigenous Peoples to reflect the diversity of Indigenous nations within Australia.

### 1.1 | Cultural safety and kidney care

Until recently, kidney care<sup>1</sup> in Australia has been dominated by western biomedical perspectives, with little or no consideration of First Nations priorities and the need for culturally safe services and

<sup>1</sup>In this article, we use the terms kidney and renal care interchangeably as this is how they are referred to in the literature over time.

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environments (Kelly et al., 2020). Literature and research utilised a deficit and colonising lens in the treatment, care and reporting of First Nations patients with chronic kidney disease. This focus shifted in the late 1990s in Australia with the introduction of cultural safety concepts and frameworks from Aotearoa/New Zealand.

In 1988, Māori nurse Irihapeti Merenia Ramsden developed a framework of cultural safety in Aotearoa/New Zealand in response to her and her student's distress at the individual and institutional racism and ongoing colonisation experienced by Māori people in healthcare settings (Nursing Council of New Zealand, 2005; Ramsden, 2002). Cultural safety is based upon the premise that care is culturally safe if it is perceived to be so by the recipients of care (Taylor & Guerin, 2019). The cultural safety framework contains five key principles for practitioners and health services to embed into care: Reflect on one's own practice; Engage in a discourse with the client; Seek to minimise power differentials between yourself and the client; Undertake a process of decolonisation; and Ensure you do not diminish, demean, or disempower others through your actions (Taylor & Guerin, 2019). Cultural safety has increasingly been embraced within Aotearoa/New Zealand and similar colonised countries such as Canada and Australia as an effective framework for working respectfully and responsively with First Nations Peoples in healthcare and research. Unlike other cultural approaches, cultural safety specifically focuses on power imbalances and the need to meaningfully address past and ongoing impacts of colonisation.

First Nations Peoples in Australia and other similar colonised countries experience disproportionately high levels of chronic diseases, including kidney failure (KF). This incidence is not related to lifestyle choice or culture but is directly linked to the ongoing impacts of colonisation, racism and poverty (structural factors) and loss of culture and language (Kerrigan et al., 2021). The impacts of colonisers declaring Australia 'Terra Nullius' (land belonging to no one) continues to reverberate across all domains of law, policy, practice and service delivery, with discrimination and racism firmly embedded into institutions and systems (Geia et al., 2020). Australian kidney services have been, and remain, inherently unsafe spaces for Indigenous Peoples, including those with KF requiring dialysis. In Aotearoa/New Zealand, the regulatory framework reflects the Treaty of Waitangi as a founding document of government in New Zealand. This treaty provides a voice for Māori People in varied constitutional arrangements and documents with consideration of impacts for Māori in all health policies and practices. Within Australia, there remains a predominant lack of Treaty or Indigenous voice within the national constitution, further highlighted on 14 October 2023 when voters rejected a proposal to recognise Indigenous people in the constitution. This is a major setback to Australia's efforts for reconciliation with its First Peoples.

Decades of research have provided evidence that a lack of culturally safe care for Indigenous Peoples continues to be a major barrier to accessible and acceptable kidney treatment and care in Australia. Institutional inertia to change and a lack of prioritisation of effective training and education of kidney service providers remains the norm in Australian kidney services (Rix, et al., 2014). Arguably, Australia lags two decades behind Aotearoa/New Zealand, where cultural safety has been

considered and included in kidney care since the mid-1990s. In 2022, the inaugural CARI *Recommendations for Culturally Safe Kidney Care for Indigenous Australians* were launched (Tunnicliffe et al., 2022). These guidelines were written over four and half years, bringing together Indigenous community voices, clinical expert opinion and published research. During this time, the emphasis and direction of the guidelines writing and content shifted from an initial western biomedical approach to a collaborative approach incorporating and prioritising Indigenous voices, preferences and knowledge. A national consultation process gathered the perspectives of First Nations communities and lived experiences of First Nations people with kidney disease (Kidney Health Australia, 2020). The authors of this paper formed the cultural safety writing group to research, guide and write the cultural safety focus for the national guidelines. This article provides a timeline and discussion of the emergence of cultural safety in Australian kidney care and research.

## 2 | METHODS

An initial systematic review of the literature was undertaken by CARI to inform the inaugural clinical guidelines for Indigenous Australians, and MEDLINE and Embase were searched with a combination of Mesh and text words used for kidney disease, Indigenous populations (Australian, New Zealand, North America) and cultural safety, cultural competency, institutional racism and education up to May 2022. Australian Indigenous Health Infonet was searched using terms for Aboriginal and/or Torres Strait Islander and kidney disease to supplement the search undertaken in the medical literature databases. This literature search was further refined by the cultural safety writing group in November 2022, with a specific focus on the emergence of culturally safe kidney care in Australia. This was undertaken with the assistance of an academic librarian as part of one of the authors' PhD studies. Key papers were identified and data extracted and placed in a table to identify when and how cultural and community considerations began to be included in Australian kidney research and practice. The results are presented chronologically to identify emergence over time and further analysed against the five principles of the cultural safety framework.

## 3 | RESULTS

Concepts of cultural care and cultural safety have emerged in kidney care literature in Australia over the last 28 years. A summary of this emergence is available in Table 1 information and is also presented here in chronological order. For a fully detailed table that tracks the emergence, see Supporting Information S1: 1.

### 3.1 | 1995–1998

The first Australian paper found to include cultural considerations alongside biomedical kidney care for Indigenous People was published in

**TABLE 1** Tracking the emergence of cultural safety.

Time period	Papers illustrating the five principles of cultural safety	1. Critical reflection	2 Engage in a discourse	3. Minimise power imbalance	4. Decolonisation	5. Do not diminish, demean, disempower
1995–1998	Bennett et al. (1995)				✓	
	Devitt and McMasters (1998a)		✓			
	Devitt and McMasters (1998b)		✓			✓
2002–2009	Cass et al. (2002)		✓	✓	✓	✓
	Kneipp et al. (2004)				✓	
	Rivalland (2006)		✓	✓	✓	✓
	Preston-Thomas et al. (2007)				✓	
	Anderson et al. (2008)		✓			✓
	Devitt et al. (2008)		✓			✓
	Burnette and Kickett (2009a)		✓	✓	✓	✓
	Burnette and Kickett (2009b)		✓			✓
2010–2012	Preece (2010)		✓	✓	✓	✓
	Marley et al. (2010)		✓			
	Anderson et al. (2012)		✓	✓		
2014–2016	Rix, Barclay, et al. (2014)	✓	✓	✓	✓	✓
	Rix, Barclay, Stirling, et al. (2014)	✓	✓	✓	✓	✓
	Rix et al. (2015)		✓	✓	✓	
	Rix et al. (2016)		✓	✓	✓	✓
	Reilly et al. (2016)		✓		✓	
	Kelly et al. (2016)	✓	✓			
2017–2019	Devitt et al. (2017)		✓	✓	✓	✓
2020–2022	Hughes et al. (2018)		✓	✓	✓	
	Chamney, M (2017)	✓	✓		✓	
	Gorham et al. (2018)		✓	✓	✓	✓
	Conway et al. (2018)	✓	✓	✓	✓	✓
	Kirkham et al. (2019)			✓	✓	✓
	Ross et al. (2019)		✓	✓	✓	✓
	Hughes et al. (2019).		✓	✓		✓
	Mick-Ramsamy et al. (2018)		✓	✓		✓
	Kelly et al. (2020)		✓	✓	✓	✓
	Schwartzkopff et al. (2020)		✓	✓	✓	✓
	Bourke et al. (2020)	✓	✓	✓	✓	✓
	Kerrigan et al. (2021)		✓	✓		✓
	Kelly et al. (2022)		✓	✓	✓	✓

1995 which explored cultural factors in the provision of dialysis and transplantation (Bennett et al., 1995). The authors included first-person quotes by Indigenous patients, identifying the importance of Kin and connection to Country in the context of kidney care.

*"I can't talk to nobody. It's hard. These ones here, they can't think well and they can't talk well. This is a lonely place. I miss the country I belongs to"* (Bennett et al., 1995, p. 614).

And:

*It's just like as though you're taken away from your own country and shot there, and your spirit wants to get back to your own country. It's just like that, so if you're so used to being in one place, it's like you left your imprints* (Bennett et al., 1995, p. 614).

This was the first time the importance of culture and Country appeared in a biomedically focused paper, highlighted by including patient voices and perspectives. However, the paper also projected mixed messages, reporting that staff were disappointed and frustrated at investing time and energy in patients who 'did not comply with treatment' and had 'self-destructive behaviours.' Deficit language within the paper linked negative patient outcomes directly to 'noncompliance,' and culture was portrayed as a barrier.

Three years later, in 1998, the book 'Living on Medicine' provided an in-depth lens on kidney disease from the perspectives of Central Australian Aboriginal communities (Devitt & McMasters, 1998a). This book highlighted the physical, cultural, and geographical aspects of living with kidney disease and the tenacity with which Indigenous kidney patients faced these issues. A paper by the same authors also published in 1998, "They don't last long": *Aboriginal patient experience of end-stage renal disease in Central Australia* (Devitt & McMasters, 1998b), further highlighted issues in relation to attending haemodialysis (HD) and the impact on cultural and family considerations and obligations. Patient voices were used to identify and define key findings and themes. For example:

*"People can't stay away from their families I can't stay here too long – can't sit down self all the time* (Devitt & McMasters, 1998b, p. S115). And: *"We want to go back bush, we're not used to living in this sort of place...go back for ceremonies, sorry business ... – we can't miss all these"* (Devitt & McMasters, 1998a, p. S115).

### 3.2 | 2002–2009

Publications from 2002 to 2009 reflected an emerging recognition of the need for novel approaches in kidney care. "Sharing the True Stories" (Cass et al., 2002) was a landmark paper from the Northern Territory (NT) that brought together the voices and perspectives of Yolgnu patients and medical, nursing, allied professionals and carers. Researchers identified significant communication barriers between Indigenous dialysis recipients and their healthcare providers. Findings identified the need for a shared understanding and awareness of cultural, social, and political contexts (Cass et al., 2002). This paper is the first known Australian kidney health publication with an Indigenous co-author.

An article by Kneipp et al. (2004), "Bring me home: Renal dialysis in the Kimberley", focused on the importance of keeping patients on Country and in their communities, re-emphasising the importance of

location. Two years later, in 2006, Rivalland reported the work of an Indigenous-owned and operated remote dialysis service and a new model of care founded on family, Country, and compassion. The Purple House, established in 2002 by the Pintupi people from the Western Desert of Central Australia, is the first known dialysis service designed, delivered, and managed by a local Indigenous community in Australia. The report highlighted that *it's more than machines and medicine: they should understand there's a Yanangu Way* (Rivalland, 2006).

The following year, the need for community-driven dialysis on Country and dialysis as close to home as possible and models to achieve this for Indigenous kidney patients was also described (Preston-Thomas et al., 2007). This was followed by "All they said was my Kidneys were dead" (Anderson et al., 2008), which privileged Indigenous voices and perspectives on kidney disease and highlighted the lack of shared understanding. One participant stated, "I gotta do my own things. I'm a bushman. I go out fishing, do my cultural stuff" (pg. 502). Another participant stated, "Before, we were living by eating really good food. Eating strong food. Now we are all sick. Whitefella food made us sick" (p. 502). The linking of historical, cultural and social barriers for Indigenous Australians can lead to low levels of trust in the advice of dominant culture health professionals and highlights the importance of the quality of the relationship and communication between Indigenous patients and health professionals.

In 2008, the inequity of access to kidney transplants for Indigenous Australians was raised, with cultural differences, protocols and miscommunication cited as barriers (Devitt et al., 2008). In 2009, two papers co-authored by kidney nurses, "Dislocation and dialysis in Aboriginal patients with renal failure" and "You are just a puppet", focused on the experience of dialysis and the cultural dislocation that being forced to move off Country creates. The impact of losing control over cultural identity and one's body were strong themes, alongside family, Country, Kinship and culture (Burnette & Kickett, 2009a, 2009b).

*"Bit lonely. Nobody to talk to here. The grandchildren cry, wanting me to go back. But I can't because there's no dialysis. "and "A couple of weeks ago I had to go to a funeral, I missed so much dialysis"* (Burnette & Kickett, 2009a).

### 3.3 | 2010–2012

In 2010, an Indigenous kidney nurse conducted and reported research exploring Indigenous perspectives on kidney care with Indigenous People's voices and quotes throughout (Preece, 2010). Strong themes emerged regarding the need for more cultural understanding and increasing self-care and self-determination. That same year, a landmark paper was published reporting equivalent or better outcomes for Indigenous patients 'dialysing on Country' in the remote Kimberly region of Western Australia. The authors cited culturally safe dialysis services in rural and remote areas as central to providing equitable care (Marley et al., 2010).

Two years later, "Looking back to my family: Indigenous Australian patients' experience of haemodialysis" (Anderson et al., 2012) argued the importance of constructing "a life that has meaning in their terms," highlighting specific and diverse concepts of illness causality and perceptions of how health and well-being are achieved. Miscommunication was a strong theme, with cultural responsibilities and the stress of juggling conflicting demands of treatment, family and cultural obligations central to the discussion.

*"I am living without my children, living far away from them. I have had to leave my home behind, and the lands, and am living in [major town] away from my friends and family." (Anderson et al., 2012, p. 4).*

### 3.4 | 2014–2016

In 2014, a paper reported findings of and recommendations from 18 yarning and storytelling interviews with Indigenous haemodialysis patients. Yarning is a conversation that encourages participants to share their own stories from the position of lived experience. It is considered a culturally safe data collection process which privileges Indigenous knowledge systems (Kennedy et al., 2022; Walker et al., 2014). Lack of cultural safety within kidney services for rural Indigenous peoples was identified. Patients reported a lack of safety in kidney services and a limited understanding of Indigenous cultural obligations. Reflective practice was identified as crucial for clinicians to provide culturally safe care (Rix et al., 2014).

In 2015, the same project team reported on the perspectives of Indigenous patients and their healthcare providers on the provision of cultural safety. The authors identified the need for service provision shaped by considerations of culture and managing the fear and apprehension of many Aboriginal patients of 'mainstream' services who had previously witnessed family members with KF as urgent priorities (Rix et al., 2015). In 2016, Rix and Indigenous Elders co-authored a paper discussing the need for cultural safety training to be delivered on-site in kidney units by Elders and family members of HD Indigenous patients (Rix et al., 2016).

A systematic review was also published in 2016, highlighting the need for accessible services, Indigenous voices to be included and care considerations of social and cultural determinants to improve the quality of care and quality of patient's lives (Reilly et al., 2016). The same year, Kelly et al. (2016) identified the need for improved cultural safety within the kidney workforce and discussed the use of journey mapping and education packages to help achieve this.

### 3.5 | 2017–2019

In 2017, Devitt et al. reported on Indigenous dialysis patients' perspectives of kidney transplantation, highlighting the need for culturally informed programmes and culturally shaped strategies as the way forward.

*"They [staff] don't give it [information] the right way. Instead of like trying to teach them, they come across like they know everything and they don't compromise on that, hey?" (Devitt et al., 2017, p. 7)*

In that same year, a kidney journal editorial questioned individual and organisational motivation to prioritise culturally safe care (Chamney, 2017). In 2018, an Indigenous patient voices forum, emphasised the need for Indigenous peoples to live at home on Country while undertaking dialysis (Hughes et al., 2018). Another 2018 paper considered how a policy shift supported by significant funding for infrastructure enabled services to be provided closer to home. While not specifically using the term cultural safety, this article focused strongly on the cultural needs of patients (Gorham et al., 2018).

Another 2018 article explored patient experiences of returning to Country and evaluated mobile dialysis models, further reiterating that dialysing on Country is an important aspect of culturally safe care (Conway et al., 2018). Another pivotal report, "Catching some air," presented Indigenous cultural leadership in kidney prevention, diagnosis and care as essential (Mick-Ramsamy et al., 2018). Authors argued that Indigenous governance needed to be supported at all levels, and the community consultations within this Indigenous-led research directly informed the inaugural CARI Indigenous clinical guidelines.

Kirkham et al. (2019) reported on their study, which aimed to enhance kidney care by incorporating patient expectations and satisfaction with care. Authors cited kidney Yarning Circle pathways within a home education programme as improving the cultural competence of health services (Kirkham et al., 2019). The same year a report on the Purple House specifically focused on cultural safety throughout. Patient preceptors with lived experience were vital. "Preceptors promote cultural safety by working with clients through appropriate relationships" (Ross et al., 2019, p. 30). Also, in 2019, Hughes et al. amplified Indigenous patient voices to report on the negative impacts of leaving Country to access dialysis care (Hughes et al., 2019).

### 3.6 | 2020–2022

A 2020 article considered the intersection between the domains of cultural safety, institutional racism, the National Safety and Quality Health Service Standards (NSQHS) and racial discrimination laws and identified and clarified gaps in kidney care and research (Bourke et al., 2020). Also, in 2020, researchers argued that the cultural determinants of health and cultural factors are vital in addressing KF (Ritte et al., 2020). These findings were based on the testimony of Indigenous Elders regarding the association between social change and risk factors for kidney disease and a more cohesive government response required to counteract devastating impacts on individuals and families. In the same year, Kelly et al. published a scoping review with the Lowitja Institute for the National Kidney Transplantation task force, synthesising evidence of cultural bias in kidney care and

healthcare more broadly. The authors re-emphasised that the quality of culturally safe care must be defined by the recipients of care (Kelly et al., 2020).

A HealthInfoNet review of kidney health identified the importance of Indigenous concepts of health and well-being, the cultural determinants of health, including culture, family, Country, connectedness and relationships. The benefits of Indigenous workforce were identified, with a recognition that cultural safety training of staff has increased; however, more work was required to address institutional and systemic racism. Patient perspectives and cultural safety were cited throughout this paper (Schwartzkopff et al., 2020).

In 2021, a research team in the NT explored the use of first-language interpreters to help address a culturally unsafe system and individual/institutional racism. Health systems prioritising interpreters within kidney care were cited as essential for the provision of culturally safe care (Kerrigan et al., 2021). In the same year, a renal team conducted a retrospective analysis of total health service expenditure (dialysis treatments, hospital admissions and ED presentations) for renal patients in the NT between the years 2008 and 2014, stratified by the model of care they received in urban, rural and remote locations. This study demonstrated dialysing on Country has the potential to reduce downstream health service use and costs (Gorham et al., 2021).

Also, in 2021, 15 studies were synthesised that explored cultural safety in kidney care in Australia, New Zealand, Canada, and the United States, with five Australian papers included. The importance of relationality, self-determination and addressing systemic barriers to access, along with addressing the legacies of colonialism for healthcare providers, were highlighted (Smith et al., 2021). A year later, a 2022 paper reported on patient voice in remote, regional, and urban areas of South Australia highlighted the importance of involving family and community in all stages of kidney care, from prevention to tertiary treatment, acknowledging community-based strengths and resilience (Kelly et al., 2022). This paper reported on community consultations that also informed the CARI clinical and cultural guidelines.

As is evident in this timeline, cultural considerations in kidney care for Indigenous Peoples first emerged in the mid-1990s. In 1995, culture was still viewed as a hindrance, leading to negative outcomes, without consideration of Indigenous Peoples' socio-economic and community situations and the impact these had on access to and engagement with healthcare services. The white lens of 'non-compliance' failed to reflect and consider the crucial role of lived experience and cultural practices (Bennett et al., 1995).

The cultural safety framework developed by Indigenous nurse Ramsden in Aotearoa/New Zealand urged nurses and health professionals to think critically about how their western worldviews impact patients and clients they care for. Healthcare professionals were encouraged to be mindful of their own sociocultural and economic privilege when working with minority groups and the need for their own critical self-reflection (Anderson et al., 2003). Cultural safety focuses on equity and systemic and individual change through

critical reflection, acknowledging the impact of colonisation and power imbalances between healthcare providers and patients (Kelly et al., 2020). Cultural safety is both a philosophy and a pragmatic process for decreasing professional and institutional racism (Sherwood et al., 2021). The concepts underpinning and embedding cultural safety, however, are often poorly understood.

While the term cultural safety was not used in papers explicitly in Australia until 2010, the key concepts of care informed and shaped by culture as defined by Indigenous People began to emerge in Australia from the mid-1990s. This contrasts with Aotearoa/New Zealand, where (Hoffman, 1997) published a paper specifically discussing cultural safety for Māori Peoples, citing the example of a Māori Elder performing a ritual cleansing of the area in a dialysis unit after a Māori patient passed within the unit.

## 4 | DISCUSSION

A deeper consideration of the emergence of cultural safety in kidney care in Australia is possible using each of the five principles of cultural safety: Reflect on one's practice; Seek to minimise power differentials between yourself and client; Communication—engage in a discourse with the client; Undertake a process of decolonisation; Ensure you do not diminish, demean, or disempower others through your actions (Nursing Council of New Zealand, 2005; Taylor & Guerin, 2019).

### 4.1 | Reflect on one's practice

Inherent within cultural safety is the recognition that one's beliefs, values and attitudes are constructed through a person's social environments, linked to childhood and life experiences. Health professionals enter their professions with their own set of beliefs, values, and attitudes. Practising in culturally safe ways requires critical self-reflection of one's worldviews and culture and how one's own biases and assumptions can impact clinical practice. The importance of building two-way trust and understanding in therapeutic relationships and the need for staff to engage with lifelong learning is a crucial step to achieving cultural safety (Power et al., 2020; Rheault et al., 2021; Rix et al., 2016). Both individual health professionals and health services and institutions are encouraged to reflect on their practice, behaviours, and responses to patient/client feedback. The recipient of care determines whether care is safe or unsafe (DeSouza, 2008), and patients/clients have the right to experience empathy and dignity in everyday relationships (Kurtz et al., 2018).

The need for critical reflection was strongly identified by Rix in her PhD project as crucial, arguing that a lack of cultural safety and inadequate recognition of diversity in cultural and social norms were major barriers in kidney care. Rix's in-depth discussion of the cultural and methodological challenges of working as non-Indigenous



Australians highlighted critical reflection by kidney nurses as key to empowering Indigenous patients and improving services (Rix, 2014).

*"Whilst I truly enjoy the company of Indigenous people, am I silently patronizing in my approach? Can I truly say that I am aware of my own racially infused attitudes? Do these attitudes come through to Indigenous people in both my spoken and unspoken communication style?"*  
(Reflective Journal entry, in 2010 (Rix, 2014, p.7).

It has been argued that any shortfall in the efficacy of health professionals' cultural safety education threatens the emergence of effective, culturally safe professionals and further embeds health inequity (McDermott, 2020). Self-reflection by health professionals on how their verbal and non-verbal communication may be impacting other people is critical. There is increasing recognition in the literature that in addition to individual practitioners examining their unconscious biases and attitudes, so too must institutions address the racial bias that is firmly embedded systemically (Kelly et al., 2020). For Institutions to become culturally safe, CEOs, policymakers, managers and frontline staff must critically reflect on service delivery for Indigenous kidney patients. Until institutions acknowledge their responsibility to provide effective training and support for all kidney care staff in self-reflection and culturally safe care, Indigenous patients are likely to remain reluctant to engage with mainstream kidney services due to continuing power imbalances (Kelly et al., 2020).

## 4.2 | Communication—engage in a discourse with the client

Communication and the ability of health professionals to engage effectively and respectfully with patients and clients are crucial to cultural safety.

From 2000 onwards, kidney health research began to reflect the importance of effective communication and of health services being guided by community reference groups, Elders, patients and Indigenous health workers to provide alternative models of culturally shaped care. In 2002, Indigenous patients described how miscommunication was pervasive, and staff needed training in inter-cultural communication as this lack of shared understanding and miscommunication were identified as major barriers to the provision of effective dialysis and kidney care. Educational resources used to support shared staff and patient learning need to include cultural, economic, and social dimensions of Indigenous people's experience of illness. Additionally increased recognition of the cultural, social, and political contexts that impact Indigenous Peoples' ability to positively engage with treatment and care is critical (Cass et al., 2002). Patients argued that healthcare professionals should consider how they speak with Indigenous peoples to ensure they communicate clearly and negotiate cultural sensitivities (Devitt et al., 2017). Fear of mainstream services is a barrier to accessing healthcare, and a lack of

culturally shaped services fosters Indigenous people's fear of kidney care services.

Kneipp et al. (2004) argued that KF rates for Indigenous People far exceeded the national rates for non-Indigenous people. This, however, can be ameliorated by keeping people home in their communities on Country, as dislocation from family and culture is damaging. In 2009, however, the themes of inability to access dialysis at home, missing family, dislocation of culture and the value of kinship were still being raised. Culture was highlighted as vital to health and well-being, as was the importance and value of Kinship and the sharing of stories and loneliness at being away from family (Burnette & Kickett, 2009a). This confirmed the significant damaging impacts of leaving Country, triggering dislocation from community and culture. In 1998, it was found that patients wanted to dialyse on Country (Devitt & McMasters, 1998a). Gorham et al. provided a timeline of dialysis evolution from 1980 to 2014 and stated there was a policy shift in 2003 toward services 'closer to home'. Being away from Country is detrimental to the health and well-being of Indigenous Australians (Gorham et al., 2018).

Miscommunication emerged repeatedly and strongly within the timeline. Rix et al. (2016) cited yarning as a culturally shaped communication strategy. Through yarning, patients exposed miscommunication, not being on Country and feeling dislocated as major barriers to accessing care. Minimising power imbalances is imperative, as Anderson et al. (2012) highlighted these impacts negatively on Indigenous patients, and remaining on Country, is one way of moving into a decolonising space.

## 4.3 | Seek to minimise power differentials between yourself and the client

Inequalities in access to the social determinants of health have their foundations in colonial histories and subsequent imbalances in power that consistently benefit some over others (Curtis et al., 2019). The strong focus on power differentials in cultural safety requires health professionals to reflect on interpersonal power differences and how the transfer of power within multiple contexts can facilitate appropriate care for Indigenous People (Kelly et al., 2020). Social and economic factors are estimated to account for more than one-third of health inequities between Indigenous and non-Indigenous Australians (Kairuz et al., 2020). The over-representation of Indigenous People with chronic diseases is directly linked to the cultural and social determinants of health (SDOH). Racism is a major cultural determinant of health (Verbunt et al., 2021).

With the increasing rates of KF amongst Indigenous Australians, the underlying socioeconomic conditions and social and cultural determinants of health need to be understood at both individual and community levels to develop, implement, target and sustain interventions (Ritte et al., 2020). There is a disconnect between Indigenous Peoples and western health services, leading to challenges when accessing care. These include unwelcome hospital settings, lack of available transport, valid mistrust of mainstream

healthcare (due to the historical lack of accountability and reparations about colonisation and its subsequent consequences on Indigenous People), a sense of alienation and inflexible treatment options, resulting in a reluctance to attend services (Durey et al., 2016). Being guided by patients and Elders as “experts” in cultural care is a much-needed power shift in kidney care and beyond (Gatwiri et al., 2021; Sherwood et al., 2015).

As identified in the timeline, an Australian Indigenous nurse published her research thesis with a strong focus on cultural considerations highlighting the power imbalances within kidney care (Preece, 2010). Significant Indigenous voices are quoted throughout. Tragically, the author commenced dialysis herself and recently passed away. As both researcher and recipient of care, Cilla was truly an ‘Indigenous expert’ who provided unique insights that resonated strongly across Australia with other Indigenous kidney patient experts (Kidney Health Australia, 2020). The landmark paper by Marley et al. in 2010 strongly advocated for dialysis on Country, reporting better or equal treatment outcomes compared to those achieved in metropolitan in-centre HD. This paper significantly challenges long-held views about better care being provided in metropolitan areas. The authors refer to the benefits of ‘dialysing on Country’ and addressing inequities in good quality care in culturally appropriate settings as essential. *“The continued creative expansion of culturally safe dialysis services in rural and remote areas .... needs to be a central part of providing equitable care to the growing number of Indigenous and Torres Strait Islander people with ESKD”* (Marley et al., 2010, p. 519).

In 2019, Indigenous patients recommended increased involvement in the co-design of preferred care models and reference groups, as a strategy to redress and level power imbalances (Hughes et al., 2019). Mick-Ramsamy et al. (2018) also focused on Indigenous cultural leadership in kidney health prevention, diagnosis, treatment, management and data governance support. Indigenous governance emerges as a key theme to enable culturally safe kidney care and reduce Indigenous Peoples’ fear and avoidance, as well as disconnection between the cultural values of patients and clinicians. The Purple House is the first known dialysis service with Indigenous governance and leadership. Purple House has led the way forward in decolonised kidney care with the provision of culturally safe services and prioritising dialysis on Country, and Indigenous governance can empower Indigenous patients and families and assist in closing the gap in power imbalances (Ross et al., 2019).

This theme continued in 2021 when a paper reported the efficacy of ‘dialysis on Country’ through a purely economic lens. It demonstrates the increased costs associated with remote dialysis service delivery are more than offset by reduced downstream health service use and costs (Gorham et al., 2021). For health systems to become efficient and effective models which can fulfil the needs of all patients, a more integrated approach to the design process is required. Co-design of health services through meaningful engagement with patients is crucial. This moves the focus from “knowing” the culture and customs of patients to remediating power imbalances by ensuring cultural safety is determined by the recipient of care

(Wilson et al., 2022). This is a key strategy to minimise and address power imbalances. Decolonising practice in clinical services has the potential to reduce inherent power imbalances.

#### 4.4 | Undertake a process of decolonisation

Earlier kidney care research in Australia was conceived and led by white researchers with a purely biomedical focus. This work took place before the emergence of shared Indigenous governance and codesign of services and research addressing Indigenous health. Systemic racism and culturally unsafe work environments have and continue to contribute to poor health outcomes for Indigenous people, leading to under-representation of Indigenous healthcare workforce, which denies and excludes access to Indigenous ways of knowing being and doing for the healthcare system itself and the people who use and work in it (Milligan et al., 2021).

In 2004, the first documented emergence of a paid patient preceptor model occurred using the term paid ‘home buddies’ (Kneipp et al., 2004). A 2019 report discussed the employment and positioning of a team of Indigenous Patient Preceptors with lived experience of kidney disease who provide expert advice and reassurance to Indigenous kidney patients (Ross et al., 2019). This is a practical example of decolonising kidney services.

In the NT, Indigenous People make up the vast majority of kidney patients. The need for a significant increase in Indigenous staff in kidney care has been reiterated by Gorham et al. (2018). Indigenous health workers are identified as the pinnacle of culturally safe care in rural and remote areas. The authors stated the promotion of an accredited Aboriginal Health Worker renal training programme as being a way to create an interface between Indigenous and western knowledge. This programme, designed in the NT, was later taken up by other states in Australia and entered the national curriculum for Aboriginal health practitioners (Gorham et al., 2018).

Decolonisation and empowerment via effective cultural safety training for staff were first mentioned by Burnette and Kickett (2009b) and reiterated by Rix et al. (2016), who recommended cultural safety education be delivered on-site in renal units for kidney staff and be delivered by Indigenous patients and Elders. The 2021 international systematic review by Smith et al. (2021) identified overarching themes of Relationality, Engagement, Healthcare self-determination and addressing systemic issues. These themes are reiterated in other recent papers (Kelly et al., 2020; Kerrigan et al., 2021; Bourke et al., 2020), highlighting the importance for healthcare providers to understand the barriers and access encountered by Indigenous People as a way to address the legacies of colonialism.

Making the necessary changes to patient outcomes from being solely focused on system-derived Key Performance Indicators (KPIs) to patient-driven priorities, which recognise the whole person, requires decolonising processes to be prioritised within research, community and clinical settings. When Indigenous voices are excluded, and services are driven by non-Indigenous clinicians,



policymakers and researchers, colonised services continue the dominance of white biomedical voices. Cultural safety education is another area requiring decolonising strategies. Within cultural safety programmes, participants are required to consider their own worldviews and recognise the pervasive nature of racism in Australian society and institutions. Furthermore, the importance of meaningful inclusion of Indigenous Peoples in decision making processes is needed to ensure “*Nothing about us, without us*” (Fredericks et al., 2020).

The Cultural Bias report (Kelly et al., 2020) provided a strong decolonising focus and made fourteen recommendations, including the inclusion of Indigenous People through the establishment of Indigenous reference groups in every transplantation unit across Australia, co-design of cultural safety models of care and feedback mechanisms. The report recommended using an institutional racism audit tool to assess levels of racism in kidney health and transplantation services and ensuring the delivery of cultural safety education for all staff in transplantation and kidney health services. Increasing flexibility within kidney services and supporting clients to attend to cultural obligations can reduce levels of disempowerment (Kelly et al., 2020). This research confirms that without strong family, cultural and community relationships, improving kidney care is impossible.

*“I felt very strange, I get very homesick when I go to hospital, for my family. I miss my house, but mostly my family, or even another Indigenous person not being in the ward.”* (Burnette & Kickett, 2009b, p. 117).

Our timeline confirms inclusion of Indigenous voices, governance and authorship in the kidney space is crucial to decolonising services.

#### 4.5 | Ensure you do not diminish, demean, or disempower others through your actions

The persistent health disparities that exist between Indigenous and non-Indigenous Australians are often perceived by the dominant culture to be the ‘fault’ of Indigenous Peoples, rather than being understood as a direct result of colonisation, inherent racism and power imbalances. There is a need to address this at both a systems and individual practitioner level. Australian First Nations nurses have identified that until governments and healthcare institutions eradicate inherent racism and power imbalances within Australian healthcare systems, the impact of these on Indigenous Australians will continue (Best & Fredericks, 2021; Kelly et al., 2020).

Rix et al. (2014) focused on the importance of addressing individual bias by utilising three Rs of relational accountability within healthcare by identifying that Respect, Reciprocity and Responsibility are critical to guiding kidney healthcare professionals to work in a culturally safer way with Indigenous kidney patients. Although this study highlighted that no single solution suits all environments, the ongoing colonial legacy uses a one-size-fits-all lens. The use of the

three Rs has the potential to improve healthcare for Indigenous People and decolonise policy, practice and everyday interactions in healthcare settings (Gatwiri et al., 2021).

## 5 | TAKE HOME MESSAGES

Reviewing the emergence of cultural safety in kidney care in Australia has provided key insights. Cultural safety approaches need to be informed by First Nations people receiving care and incorporate the five principles of critical reflection, communication, addressing power imbalances, decolonisation and ensuring one does not demean, dismiss or disempower. Until cultural safety education and practice are implemented consistently within kidney care environments nationally, racism and power imbalances will remain. The inclusion of patient and community voices, culture, community, Family and clinical considerations within the inaugural CARI guidelines is a positive step forward; this now needs to be implemented into daily clinical care. As evident by this review and timeline, kidney care in Australia is on the path of ensuring First nations people receive culturally safe care, but there is much more work yet to do.

Healthcare staff must have an open and caring approach towards Indigenous kidney patients and their families. Being critically reflective and striving toward a deeper understanding of how racist attitudes and prejudices impact care involves going on a lifelong cultural safety journey. All healthcare providers challenging and questioning their worldviews, and the systems and structures that govern people's lives is urgent (Moorley et al., 2020). If language is not decolonised, this continues to actively oppress Indigenous Peoples, perpetuating a colonising process that began with invasion, resulting in disparities in healthcare outcomes and fear of mainstream services (Canuto & Finlay, 2021). The emerging studies of embedding cultural safety into practice provide a solid base to work on; however, there is a need to ensure the momentum continues. Power sharing reduces biomedical dominance, and with active listening and reflection on the part of the healthcare providers, Indigenous kidney patients will be freer to use their agency to define the type of care they want. Cultural safety is the key to truly working in partnership, increasing Indigenous governance, respectful collaboration, and ‘redesign’ kidney care. This may require healthcare staff to undertake anti-racism training.

## 6 | THE WAYS FORWARD

Until we actively listen to patients, act upon their needs, involving them in decision making in their own health journey and kidney care, we will not know if we are providing culturally safe and responsive care. The CARI guidelines cite addressing institutional racism as the number one priority, recommending dialysis on Country and Indigenous workforce. Ensuring all healthcare staff working in kidney care base their treatment and care on these guidelines is the next major challenge. Then, finding a way to evaluate cultural safety by Indigenous patients is the subsequent

challenge. If we act with cultural safety within our nursing practice, we will minimise individual-level racism; the mitigation of institutional racism requires the institution to buy in and prioritise and build accountability for cultural safety at the system level.

As identified by kidney care expert with lived experience and key advocate Kelli Owen:

*"The voices I represent are so very tired of small steps without follow through. We have generations of grief and trauma sitting on our shoulders when we look to the future... we want fundamental changes happening NOW to allow us to live longer with our families. We want to not be continually faced by institutionalised and personal racism when we access treatment... here today, and for this point onwards, we all have an opportunity to decolonise our systems and processes together!"*

CARI Guideline Launch Speech, October 16th, 2022, Kelli Owen, Kaurna, Narungga & Ngarrindjeri woman.

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The authors declare no conflict of Interest.

## DATA AVAILABILITY STATEMENT

Not applicable.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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